STATE OF CALIFORNIA
DEPARTMENT OF CORRECTIONS AND REHABILITATION
OPOS 07RK (3/07)

OFFICE OF PEACE OFFICER SELECTION

PEACE OFFICER
REFRACTIVE SURGERY CLINICAL EXAMINATION REPORT

Applicants: The California State Personnel Board requires that applicants for peace officer positions who have had refractive eye surgery submit regular reports from their doctors for one year. If you have had or plan to have refractive eye surgery of any kind, please take this package to your doctor. Your doctor is to complete the reports as indicated and mail them directly to:

California Department of Corrections and Rehabilitation
Attn: Pre-Employment Medical Unit
2201 Broadway
Sacramento, CA 95818-2572

Candidate's Name: _____
PRINT *Last* *First* *MI*

Address: _____
Street *City* *State* *ZIP*

SSN: _____ **Telephone Number:** ( ) _____

CLASSIFICATION: **(Circle One)** **CO** **YCO** **YCC** **Other**____

AUTHORIZATION TO RELEASE INFORMATION

To determine my eligibility for employment as a Peace Officer with the California Department of Corrections and Rehabilitation (CDCR), I authorize you to release to CDCR any and all medical information and/or records concerning my vision. This authorization is valid until the selection process is completed.

Candidate's Signature: _____ **Date:** _____

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Return completed forms to:

California Department of Corrections and Rehabilitation
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2201 Broadway
Sacramento, CA 95818-2572

REFRACTIVE EYE SURGERY EVALUATION CRITERIA

To Optometrist/Ophthalmologist:

Your patient is seeking employment as a peace officer, a public safety position and has informed us that he/she has undergone (or plans to undergo) refractive eye surgery (i.e., RK, PRK, Lasix, laser, etc.) He/she must demonstrate stable visual function prior to appointment as follows:

1. Visual acuity in each eye must be stable over at least a 12-month period of time after surgery.
2. Visual acuity must meet the corrected and uncorrected standard for the class being tested.

Classification	Visual Acuity Requirements
Correctional Officer	20/60 uncorrected in each eye and corrected to 20/20
Youth Correctional Officer	20/60 uncorrected in each eye and corrected to 20/20
Youth Correctional Counselor	20/60 uncorrected in each eye and corrected to 20/20
Medical Technical Assistant	20/200 uncorrected in each eye and corrected to 20/20

3. Glare disability and contrast sensitivity must be normal.
4. Post-operative complications must have been resolved for at least six months.
5. On behalf of your patient, please supply the information requested below when the Clinical Examination Reports document stability.
   A. Submit a copy of the operative reports and copies of all doctor's progress notes since surgery.
   B. List the date(s) of surgery on each eye.
   C. List the date that the applicant became free of post-operative complications.
   D. List the surgical protocol followed (i.e., Saulson, Thorton, Ellis, other—please name) and a description of the protocol.
   E. List sensitivity to any environmental factors (i.e., heat, cold, smog, dust, etc.)
   F. Complete and submit the Clinical Examination Reports.

The information will be used to determine your patient's stability of vision after refractive surgery. Visual acuity should be measured using a Bailey-Lovie acuity chart or other standardized chart used for acuity measurements. Acuity should be measured in the morning and again in the late afternoon (allowing at least 6 hours between exams). Percent glare disability should be measured in each eye before and after cyclopegia. Please list the instrument used and the expected normal values. All post-operative examinations must be at least three months apart for our purposes (this protocol does not preclude other examinations if you determine they are necessary). Cyclopegic exams should be performed after using 1% mydriacyl for paralysis of accommodation.

Please send the reports to: California Department of Corrections
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Sacramento, CA 95818-2572

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2201 Broadway
Sacramento, CA 95818-2572

Exam Date: _____

PRE-OPERATIVE CLINICAL EXAMINATION REPORT

Applicant: _____
Social Security Number: _____

Examiner: _____
Address: _____
_____
Telephone Number: _____

1. Visual Acuity* (Dimly lit room)
   Without Correction — OD _____ OS _____
   With Correction — OD _____ OS _____
2. Manifest Refraction — OD _____ OS _____
3. Tonometry — OD _____ OS _____ OD _____ OS _____

*Please specify method used to measure acuity: _____

Doctor's Original Signature	Date
Doctor's Printed Name	Telephone Number
Doctor's Address City, State Zip Code	

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Return completed forms to:

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Exam Date: _____

Surgery Dates

Right eye: _____

Left eye: _____

POST-OPERATIVE CLINICAL EXAMINATION REPORT #1
(Six Months)

Applicant: _____ Examiner: _____

Social Security Number: _____

	Morning Exam			Afternoon Exam*			
1. Visual Acuity** (Dimly lit room) Without Correction	OD _____	OS _____		OD _____	OS _____		
With Correction	OD _____	OS _____		OD _____	OS _____		
2. Manifest Refraction	OD _____		_____	OD _____	OS _____		
	OS _____		_____	OD _____	OS _____		
3. Tonometry	OD _____	OS _____		OD _____	OS _____		
	OD _____	OS _____		OD _____	OS _____		
4. Cycloplegic Exam***							
A. Pupillary Size				OD _____	OS _____		
B. Refraction after cycloplegia				OD _____	OS _____		
C. Slit lamp exam				_____			

*Please allow six hours between morning and afternoon exam.
**Please specify method used to measure acuity: _____
***Use 1% mydriacyl for cycloplegia.

Doctor's Original Signature	Date
Doctor's Printed Name	Telephone Number
Doctor's Address City, State Zip Code	

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2201 Broadway
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Exam Date: _____

Surgery Dates

Right eye: _____

Left eye: _____

POST-OPERATIVE CLINICAL EXAMINATION REPORT #2
(Nine Months)

Applicant: _____ Examiner: _____

Social Security Number: _____

	Morning Exam		Afternoon Exam*	
2. Visual Acuity** (Dimly lit room) Without Correction	OD _____ OS _____		OD _____ OS _____	
With Correction	OD _____ OS _____		OD _____ OS _____	
5. Manifest Refraction	OD _____	_____	OD _____	OS _____
	OS _____	_____	OD _____	OS _____
6. Tonometry	OD _____ OS _____		OD _____ OS _____	
	OD _____ OS _____		OD _____ OS _____	
7. Cycloplegic Exam***				
D. Pupillary Size			OD _____	OS _____
E. Refraction after cycloplegia			OD _____	OS _____
F. Slit lamp exam			_____	

*Please allow six hours between morning and afternoon exam.
**Please specify method used to measure acuity: _____
***Use 1% mydriacyl for cycloplegia.

Doctor's Original Signature	Date
Doctor's Printed Name	Telephone Number
Doctor's Address City, State Zip Code	

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Return completed forms to:

California Department of Corrections and Rehabilitation
Attn: Pre-Employment Medical Unit
2201 Broadway
Sacramento, CA 95818-2572

Exam Date: _____

Surgery Dates

Right eye: _____

Left eye: _____

POST-OPERATIVE CLINICAL EXAMINATION REPORT #3
(12 Months)

Applicant: _____ Examiner: _____

Social Security Number: _____

	Morning Exam		Afternoon Exam*	
3. Visual Acuity** (Dimly lit room) Without Correction	OD _____ OS _____		OD _____ OS _____	
With Correction	OD _____ OS _____		OD _____ OS _____	
8. Manifest Refraction	OD _____	_____	OD _____	OS _____
	OS _____	_____	OD _____	OS _____
9. Tonometry	OD _____ OS _____		OD _____ OS _____	
	OD _____ OS _____		OD _____ OS _____	
10. Cycloplegic Exam***				
G. Pupillary Size			OD _____	OS _____
H. Refraction after cycloplegia			OD _____	OS _____
I. Slit lamp exam			_____	

*Please allow six hours between morning and afternoon exam.
**Please specify method used to measure acuity: _____
***Use 1% mydriacyl for cycloplegia.

Doctor's Original Signature	Date
Doctor's Printed Name	Telephone Number
Doctor's Address City, State Zip Code	